KeyShare

Notification of Changes to Your Member Handbook
The Local Choice Health Benefits Program

This booklet consolidates notifications to the KeyShare health benefits plan from April 14, 2003 through July 1, 2004 and October 1, 2004 for some school groups. You may replace individual notification documents with this consolidated booklet. Keep this booklet with your KeyShare Member Handbook, #T20241 (6/02) for a full and complete description of your coverage. You or your Benefits Administrator may view and print this Member Handbook from The Local Choice Web site at **www.thelocalchoice.virginia.gov** or from Anthem Blue Cross and Blue Shield's site at **www.anthem.com**.

1) **Your plan is administered by four plan administrators, as follows: Anthem Blue Cross and Blue Shield for medical benefits; Delta Dental of Virginia for dental benefits; Medco Health Solutions, Inc. for prescription drug benefits; and ValueOptions, Inc. for behavioral health (mental health and substance abuse treatment) and EAP benefits.** **Effective July 1, 2004**

2) **Your plan includes special provisions for prescription drug refills when traveling.** **Effective July 1, 2004**

   If you are planning to travel on vacation or leaving home for an extended period, you may need one or more early refills of your medication. Participating retail pharmacies and the Medco Health Home Delivery Pharmacy Service may provide one early refill (up to a 34-day or 90-day supply, as appropriate) to accommodate travel. However, for extended travel, multiple refill requests must be sent to:

   The Department of Human Resource Management (DHRM)
   Office of Health Benefits
   Attn: State Health Benefits Program
   101 North 14th Street, 13th Floor
   Richmond, VA 23219
   E-mail: **tlc@dhrm.virginia.gov**

   Please include documentation of your dates of travel, the names of any prescriptions that you wish to request, and the number of refills that you will need. DHRM will evaluate your needs and approve all valid requests. If at all possible, please allow at least two to three weeks for processing your request. Also, please keep in mind that you will never be allowed to obtain more refills than you have been prescribed. That is, if your one-year prescription runs out in six months, you cannot get more than six one-month refills.

   Page 33 – Outpatient Prescription Drugs

TLC T20402 (7/04)

3) **The adult wellness services (routine mammogram, Pap test, Prostate Specific Antigen (PSA) test, digital rectal exam and colorectal cancer screening) are no longer subject to the plan year deductible.** **Effective July 1, 2004**

Page 3 – Summary of Benefits
Page 27 – Professional Services

4) **Chronic obstructive pulmonary disease (COPD) has been added to the Anthem Better Prepared (formerly called Trigon Disease Management) program.** **Effective July 1, 2004**

Page 22 – Trigon Disease Management Program

5) **You may now obtain durable medical equipment from an Anthem network provider (listed under Ancillaries – Durable Medical Equipment in the Anthem medical provider directory), *or* any other equipment provider. However, if you obtain equipment from a non-network provider, the provider may bill you for the difference between the plan's allowable charge and the provider's charge.** **Effective July 1, 2004**

Page 28 – Other Health Services, item 1)

6) **Your plan covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally. The plan pays 100% for covered infusion therapy services.** **Effective July 1, 2004**

7) **If dental services for a single procedure or series of procedures cost more than $250, your dentist may submit a predetermination plan to Delta Dental before services are provided. By submitting a predetermination plan, you and your dentist will be informed of: the total costs associated with the procedure(s); the exact amounts that will be covered by your health plan; and the portion of the charges for which you will be responsible. A predetermination plan is not required by your health plan, but recommended when extensive dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.** **Effective July 1, 2004**

Page 36 – Dental Services

8) **The following list replaces Services Which Are Eligible for Reimbursement shown under Dental Services in your handbook.** **Effective July 1, 2004**

Diagnostic and preventive services (routine)

Your health plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious dental problems. Covered services include:

- two routine oral evaluations per plan year;
- two dental prophylaxes (cleanings) per plan year, including scaling and polishing of teeth;
- dental x-rays (except x-rays needed to fit braces);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two tests to see if a tooth is still alive (pulp vitality tests) per plan year;
- care for a toothache (palliative emergency care);
- two sets of bitewing x-rays (two or more films) per plan year;
- one complete full mouth x-ray series or a panorex every 36 months (the 36-month count starts the month in which you receive the x-ray series or panorex);
- two topical fluoride applications per plan year only to covered persons under age 19;
- dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to covered persons under age 19;
- diagnostic casts;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders;

- occlusal night guards for demonstrated tooth wear due to bruxism; and
- biopsy of oral tissue.

Primary services (routine)

After your dentist has examined your teeth, you may need additional dental work. Your health plan includes coverage for the following:

- fillings (amalgam or tooth-colored materials);
- pin retention;
- pulling teeth (either a simple extraction or surgical removal, except surgical removal of impacted teeth which is covered under oral surgery);
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- making the gum ridges ready for false teeth;
- re-cementing existing crowns, inlays and bridges;
- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty)
- scaling and root planning of the gum;
- stainless steel crowns;
- sedative fillings;
- therapeutic pulpotomy for primary “baby” teeth only;
- periodontal evaluations;
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical dental service;
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance therapy; and
- trips by the dentist to your home if you need any of the services you see listed here.

Page 36 – Dental Services

9) Your plan includes *non-routine* dental services that are covered separately from your routine dental benefits. The following constitutes a new section in your handbook and replaces all previous references to non-routine dental services throughout your handbook.

Effective July 1, 2004

NON-ROUTINE DENTAL SERVICES

The following non-routine dental services are eligible for reimbursement under your medical benefits, subject to the plan year deductible.

- medically necessary dental services resulting from an accidental injury while covered under the plan if a plan of treatment from the dentist or oral surgeon is submitted to Anthem within 60 days of the date of the injury and subsequently approved (injury as a result of chewing or biting is not considered an accidental injury);
- medically necessary dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while you are covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;

- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

These services are covered as professional provider or facility services subject to the appropriate copayment:

- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician, that such services are required to effectively and safely provide dental care.

10) The following list replaces the <u>Special Exclusions</u> section under Dental Services in your handbook. <u>Effective July 1, 2004</u>

Your coverage does not include benefits for the following dental services:

- services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral, inhalation or intravenous (IV) sedation;
- bleaching of discolored teeth;
- dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- pulp capping (direct or indirect);
- upgrading of working dental appliances;
- precision of working for dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with OSHA requirements;
- separate charges for routine irrigation of re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- general anesthesia except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying dental service is a covered benefit;
- diagnostic photographs;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- preventive control programs, or oral hygiene instructions;
- complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under this plan or any similar coverage;
- dental services for lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices);
- other services that Delta Dental determines are for the purpose of correcting congenital malformations, and cosmetic surgery or dentistry for cosmetic purposes;
- dental services for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correcting developmental malformations or for esthetic purposes;
- services billed under multiple dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes; and

- any dental services not listed as covered or services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account general accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

Page 36 – Dental Services

11) The following is no longer excluded from your coverage: Services for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities. **Effective July 1, 2004**

Page 40 – Exclusions, number 28)

12) The exclusion regarding medically necessary services and supplies is replaced as follows:
Effective July 1, 2004

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by Anthem or ValueOptions at their sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem or ValueOptions' decision that a service is not medically necessary.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required preauthorization, the following professional provider services that you received during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:
For inpatients
1. services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For outpatients - services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

Page 54 – Exclusions, number 25)

13) Appeals under General Rules Governing Benefits is replaced as follows:
Effective July 1, 2004

Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should you have a problem or question about your health plan, the appropriate plan administrator's member services department will assist you. Most problems and questions can be handled in this manner. For medical benefits your plan administrator is Anthem. For behavioral health and EAP benefits your plan administrator is ValueOptions. Delta Dental is the plan administrator for routine dental and the optional expanded dental benefits. Medco Health is the plan administrator for your prescription drug benefits. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about your health plan's services, quality of care, the choice of and accessibility to your health plans' providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your health plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of your health plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Important: Written complaints or any questions concerning your medical, behavioral health, dental or prescription drug coverage may be filed to the following address:

Anthem Blue Cross and Blue Shield (for medical)
Attention: Member Services
P. O. Box 27401
Richmond, VA 23279

Delta Dental Plan of Virginia (for dental)
4818 Starkey Road, S. W.
Roanoke, VA 24104

Medco Health Solutions, Inc. (for prescription drug)
Call 800-355-8279

ValueOptions, Inc. (for behavioral health)
P. O. Box 12438
Research Triangle Park, NC 27709-2438

Appeal Process

Your health plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision you find unacceptable. There are two types of appeals:

- Plan administrator appeals are requests to reconsider coverage decisions of pre-service or post-service claims. A separate expedited emergency appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain. All appeals to the plan administrator must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).
- After plan administrator appeals are exhausted, you may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the plan administrator. Additionally, other plan related issues may be appealed to DHRM as well. More information about this appeal may be found in the **Final DHRM Appeal Process** section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation to the appropriate plan administrator's address (see addresses in this section) of why you feel the coverage decision was incorrect. (Alternatively, Anthem will accept a verbal request for appeal by calling a member services representative.) You may provide any comments, documents or information that you feel the plan administrator should consider when reviewing your appeal. Please include with the explanation:

- The patient's name, address and telephone number;
- Your identification and group number (as shown on your identification card); and
- The name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Addresses:

Anthem Blue Cross and Blue Shield
Attn: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Medco Health Solutions, Inc.
Attn: Coverage Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

Delta Dental Plan of Virginia
Attn: Appeals
4818 Starkey Road, S.W.
Roanoke, VA 24104

ValueOptions, Inc.
P.O. Box 12438
Research Triangle Park, NC 27709-2438

How the plan administrator will handle your appeal

In reviewing your appeal, the plan administrator will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The plan administrator will resolve and respond in writing to your appeal within the following time frames:

- For pre-service claims, the plan administrator will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims, the plan administrator will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, the plan administrator will respond orally within one working day after receipt from the member or treating provider of the request to appeal, and will then provide written confirmation of its decision to the member and treating provider within 24 hours thereafter.

When the review of your appeal by the plan administrator has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- Any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- The explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- The identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

Final DHRM Appeal Process

To further appeal the final coverage decision made by your health plan through its internal appeal process, you must submit to the director of the Commonwealth of Virginia, Department of Human Resource Management, in writing within 60 days of your health plan's denial, the following:

- Your full name;
- Your identification number;
- The date of the service;
- The name of the provider for whose services payment was denied; and
- The reason you think the claim should be paid.

You are responsible for providing DHRM with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in this review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as policy or eligibility issues will be reviewed by the director of DHRM. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization.

For issues of medical necessity, the medical review organization will examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the medical review organization will:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

With other plan-related appeals to DHRM, if after review, the denial is upheld, that denial is final.

Beyond any final denial, you may appeal that determination as per the provisions of the Administrative Process Act within 30 days of the final DHRM determination.

You may download an external appeals form at **www.thelocalchoice.virginia.gov.**

Notice in Writing

A notice sent to you by a plan administrator (Anthem, ValueOptions, Delta Dental or Medco Health) is considered "given" when delivered to the Department of Human Resource Management or your benefits administrator. If the Commonwealth of Virginia, or any one of the plan administrators must contact you directly, a notice sent to you is considered "given" when mailed to the enrolled member at the address shown in the Commonwealth of Virginia's records. Be sure to notify the Department of Human Resource Management if your address changes.

Page 6 – General Rules Governing Benefits, number 11)

14) Continuation of Coverage under Basic Plan Provisions, is replaced as follows:

Effective July 1, 2004

Extended Coverage

Extended Coverage (for employers with 20 or more employees) is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. Extended Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees or retiree group participants, and dependent children of employees or retiree group participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost of coverage plus an administrative fee.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan due to the occurrence of any of the following qualifying events:

- The parent/employee/retiree group participant dies;
- The parent's/employee's hours of employment are reduced;
- The parent's/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, causing the child(ren) to lose eligibility; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer Extended Coverage to qualified beneficiaries only after the benefits administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Commonwealth of Virginia will be responsible for providing qualified beneficiaries with their right to elect Extended Coverage.

For other qualifying events (divorce of the employee/retiree group participant and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you (or any individual representing the qualified beneficiaries) must notify your benefits administrator. The Plan requires you to notify the benefits administrator within 60 days of the date coverage would be lost due to the qualifying event. Your designated benefits administrator must be provided with written notification including the following information:

- The type of qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Once the benefits administrator receives timely notice that a qualifying event has occurred, Extended Coverage will be offered to the qualified beneficiaries. For each qualified beneficiary who makes a timely Extended Coverage election (as defined in the Election Notice), Extended Coverage will begin on the date that Plan coverage would have been lost due to the qualifying event. Failure to provide timely and complete notification of the qualifying event will result in loss of Extended Coverage eligibility.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee or retiree group participant, your divorce, or a dependent child losing eligibility as a dependent child, Extended Coverage lasts for up to 36 months.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. Upon receiving notice of the event, as defined above, the benefits administrator must make Extended Coverage available and effective on the date of the event, but not before.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, Extended Coverage lasts for up to 18 months. There are two ways in which this 18-month period of Extended Coverage can be extended.

Disability Extension of 18-Month Period of Extended Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of Extended Coverage and you notify your benefits administrator in a timely fashion (as defined below), you and your entire family can receive up to an additional 11 months of Extended Coverage, for a total maximum of 29 months. You (or any individual representing the qualified beneficiaries) must make sure that your benefits administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of Extended Coverage. In addition, the following information must be provided in writing:

- the name of the affected qualified beneficiary (e.g., spouse or dependent child);
- the date of the determination;
- documentation from the Social Security Administration to support the determination;
- the written signature of the notifying party.

Failure to provide timely and complete notification of the disability determination will result in loss of eligibility for the extension.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving Extended Coverage, the spouse and dependent children in your family can get additional months of Extended Coverage up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you (or any individual representing the qualified beneficiaries) must make sure that your benefits administrator is notified of the second qualifying event within 60 days of the date coverage would be lost due to the second qualifying event. This notice must be delivered (by mail or hand delivery) to your benefits administrator in writing and include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of Extended Coverage eligibility.

In addition, when an employee's qualifying event (e.g., termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's covered spouse and dependent children (but not the employee) become entitled to Extended Coverage for a maximum period that ends 36 months after the Medicare entitlement.

If You Have Questions

If you have additional questions about Extended Coverage, you should contact your benefits administrator or the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Active or former employees (and their covered dependents) may contact the designated benefits administrator within their employing agency. Retiree group participants (and their covered dependents) should contact the Virginia Retirement System or, for Optional Retirement Plan or Local Retirees (and their covered dependents), their pre-retirement agency's benefits administrator. The EBSA can address provisions of COBRA that also apply to the Public Health Service Act. Addresses and phone numbers are available through EBSA's Web site at **www.dol.gov/ebsa.**

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your benefits administrator informed of any changes in your address or the addresses of family members. You should also keep a copy, for your records, of any notices you send to your benefits administrator.

Page 44 – Basic Plan Provisions, number 9)

15) Your plan had added a feature in which deductible amounts incurred from April 1 through June 30 carry over to the new plan year that starts July 1. **Effective July 1, 2004**

16) Contact Anthem Member Services directly at (804) 355-8506 in Richmond or 1-800-552-2682 outside Richmond for Hospital Admission Review before you are admitted to the hospital as an inpatient.

Benefit Clarification July 1, 2004

Page 4 – Who to Contact For Assistance

17) Your plan covers special medical formulas which are the primary source of nutrition for yourself or covered family members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Benefit Clarification July 1, 2004

Page 28 – Other Services

19) Your plan covers the private room charge in a hospital if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the hospital only has private rooms.

Benefit Clarification July 1, 2004

Page 11 – Hospital Services

20) The requirement to choose a primary care physician in order to receive the highest level of covered benefits, and the requirement that your primary care physician refer you to a specialist for care not rendered by your primary care physician has been removed. All references to payment levels reduced by 25 percentage points for covered services rendered without a referral no longer apply. **Effective July 1, 2003**

Page 5 – Services of a Primary Care Physician
Page 58 – Definitions (Referral)

21) The BlueCard® program has been added to your plan, as follows: **Effective July 1, 2003**

BlueCard® PPO for Care within the United States

If you need medical care outside the Anthem network and within the United States, you will have access to care from a BlueCard PPO provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These providers accept your copayment or coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for you, and have agreed to accept the allowable charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **1-800-810-BLUE (2583)**. Or use the BlueCard Doctor and Hospital Finder on the Web at **www.bcbs.com**. Providers can also tell you if they participate in BlueCard PPO when you call to make an appointment.

Simply present your Anthem ID card when you receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

The amount used to calculate your payment responsibility for a covered service will usually be the lower of:

- The billed charge for the covered service; or
- The negotiated price passed on to Anthem through the BlueCard program.

Often, this "negotiated price" will consist of a simple discounted price. It can also be an estimated or average price allowed by the BlueCard program and the terms of your health care plan. An estimated price takes into account special arrangements with a provider or provider group that include settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices. Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield plan to use another method for calculating the charge, or add a surcharge to your liability calculation. In these states, Anthem Blue Cross and Blue Shield would calculate your liability according to the applicable state law in effect when you received care.

BlueCard Worldwide® for Care outside the United States

If you live or travel outside the United States, the BlueCard Worldwide program assists you to obtain inpatient and outpatient hospital care and physician services.

Follow these steps *before* you travel:

1. Obtain a list of BlueCard Worldwide hospitals located where you will be traveling or staying. You may obtain this information on the Web at **www.bcbs.com.** Select "Healthcare Anywhere" then "PPO Coverage". Or you may call **800-810-BLUE (2583)** for assistance.
2. Be sure to carry your Anthem medical ID card with you and present it when you need inpatient care.

If you need care once you arrive at your destination, follow these simple steps:

Inpatient Hospital Care

1. Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.). A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BlueCard Worldwide hospital. It is important that you call the Service Center in order to obtain cash-less access for inpatient care. The hospital will submit your claim for you. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.
2. Call Anthem Member Services at **804-355-8506** for hospital admission review.

<u>*Emergency:*</u>
Bypass the above steps. Go to the nearest hospital. Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.) if you are admitted to arrange cash-less access (available in most cases). A BlueCard Worldwide Service Center representative will assist you. A family member or friend can make this call for you.

Outpatient Hospital Care/Physician Services

1. Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.) if you would like information on physicians or outpatient facilities. A BlueCard Worldwide Service Center representative will accept the charges, and if you want, make an appointment with a doctor for you, or will direct you to a hospital.

2. You will need to pay for your care and then submit a claim using the International Claim Form to the BlueCard Worldwide Service Center (address is on the claim form). Contact the Service Center for the form, or you may download the form on the Web at **www.bcbs.com.** Select "Healthcare Anywhere", then "I need health care outside of the U.S.".

22) The following paragraph is added to item 6) Prompt Filing Claims, under the Basic Plan Provisions section: **Effective July 1, 2003**

Your health plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or the provider furnishing the additional information. You or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by your health plan, you will receive written notification of the coverage decision.

Page 43 – Prompt Filing of Claims

23) Under Eligibility, the Dependents section regarding unmarried biological and adopted children, and disabled children, is changed as follows: **Effective July 1, 2003**

Unmarried biological and adopted children may be covered by the The Local Choice Health Benefits Program to the end of the year in which they turn age 23 if the child lives at home and can be claimed on the parent's federal income tax return. There are limited circumstances which would allow eligibility under the plan even if the child does not live at home. Examples include:

- The child lives with the other parent if the employee is divorced, and
- The child lives away from home while attending college or boarding school.

Disabled adult children may be covered if the qualifying disability was diagnosed prior to the loss of eligibility for coverage due to age and has been approved by the plan administrator. Enrollment must occur within 31 days of loss of coverage as dependent children due to age. ***A child who later recovers is no longer eligible and may not re-enroll.***

Children who are age 19 or older may not be covered by The Local Choice Health Benefits Program if they are not eligible to be claimed on the employee's income tax return as a dependent (i.e., children who are self-supporting).

Page 61 – Eligibility, Dependents

24) Routine mammogram coverage has been changed to cover *one routine screening mammogram each year for members age 35 and older.* **Effective July 1, 2003**

Page 12 – Institutional Services, item 6)
Page 23 – Professional Services, item 2)

25) The $500 calendar limit for spinal manipulation and other manual medical intervention visits apply to a licensed chiropractor and *any other licensed medical provider.*
Effective July 1, 2003

Page 31 – Chiropractic Services

26) The following laboratory services shown under Professional Services are also covered under Institutional Services: **Effective July 1, 2003**

- One annual Pap smear
- One annual routine prostate specific antigen (PSA) test (age 40 and over)

- Colorectal cancer screenings for members age 40 and over as outlined: one annual fecal occult blood test, and one annual flexible sigmoidoscopy, or colonoscopy or double contrast barium enema
- Routine laboratory services performed in conjunction with wellness check-up (age 7 through adult)

Page 11 – Institutional Services

27) Certain drugs may not be available through the mail service (home delivery) pharmacy due to distribution restrictions imposed by the drug manufacturer. However, these drugs are available through the network retail pharmacies at their appropriate retail copayment level.

Benefit Clarification July 1, 2003

Page 33 – Outpatient Prescription Drugs

28) Disclosure of Protected Health Information to the Employer **Effective April 14, 2003**

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan-means the "State and Local Health Benefits Programs."

(b) Employer-means the local employer group

(c) Plan Administration Functions-means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(d) Health Information-means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(e) Individually Identifiable Health Information-means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the TLC individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(f) Summary Health Information-means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for

providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR § 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that of their intent to abide by these provisions.

Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;

(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);

(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR §164.524;

(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR § 164.526;

(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR § 164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and

(i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR § 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Employer’s Executive Contact
- Employer’s Benefits Administrator

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered "failure to comply with established written policy" (a Group II offense) and must be addressed under the Commonwealth of Virginia's Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR § 164.520.

SUMMARY OF KEYSHARE BENEFITS
Effective July 1, 2004

The following table is an update to the Summary of Benefits on page 2 of your Member Handbook.

	Covered Services	**In-Network You Pay**
Plan Year Deductible	Applies to both medical and mental health benefits.	Your Plan Year Deductible: $200 per covered person, not to exceed $600 per family
Plan Year Out-of-Pocket Expense Limit	Applies to both medical and mental health benefits. Once You have met Your out-of-pocket expense limit for the Plan Year, the plan pays 100% of the Allowable Charge (AC)** for in-network services. (Certain expenses do not count toward this limit as defined on page 9.)	Your Plan Year Limit: $2,000 per covered person, not to exceed $6,000 per family
Inpatient Hospital	Semi-private room or intensive care unit. Includes ancillary services.	20% Coinsurance after Deductible
Outpatient Hospital	Facility charge for outpatient department of a Hospital or Hospital emergency room	20% Coinsurance after Deductible
Skilled Nursing Facility	Up to 180 days per Plan Year in Network Skilled Nursing Facility	20% Coinsurance after Deductible
Home Health Care	Up to 90 Visits per Plan Year	20% Coinsurance after Deductible
Professional Services	• Inpatient Physician Care	20% Coinsurance after Deductible
	• Outpatient Physician Visit in office or Hospital ▪ Primary care ▪ Specialty care	$20 per PCP Visit; $30 per Specialist* Visit
	• Maternity Services	$20 per PCP per pregnancy $30 per Specialist Visit per pregnancy
Physical/Speech/ Occupational Therapy	• Physical Therapy • Speech and Occupational Therapy	$30 per Specialist Visit
Chiropractic Services	Plan pays $500 per Plan Year for spinal manipulation and other manual intervention visits	$30 per Specialist Visit
Diagnostic Tests and Laboratory Services	Physician office, clinical reference lab, or outpatient hospital	20% Coinsurance after Deductible
Outpatient Prescription Drugs *(Mandatory generic)*	• Retail up to 34-day supply (You may purchase up to a 90-day supply at a retail pharmacy by paying multiple Copayments.) • Home Delivery Pharmacy Service up to a 90-day supply *(If You choose the brand when a generic is available, You pay Copayment plus 100% of the difference between the generic drug Allowable Charge and the brand drug Allowable Charge.)*	Tier 1: $15 Tier 2: $20 Tier 3: $35 Tier 1: $18 Tier 2: $33 Tier 3: $63
Dental	Plan pays $1,200 per member per Plan Year • Diagnostic and preventive services • Primary services	 $0 20% Coinsurance, no Deductible

	Covered Services	In-Network You Pay
Well Child Care (up to 7th birthday)	• Well child care visits (up to 7th birthday) • Immunizations, laboratory services and x-rays	$20 per PCP Visit; $30 per Specialist Visit 20% Coinsurance, no Deductible
Wellness Services (Age 7 - adult)	• Wellness check-up (one per Plan Year) • Routine immunizations, preventive screenings, laboratory and x-rays in conjunction with wellness check-up. *(Plan pays 80% up to $150 per member per Plan Year.)*	$20 per PCP Visit; $30 per Specialist Visit 20% Coinsurance, no Deductible
Other Adult Wellness Services	• Routine mammography screening and reading • Annual PSA test, digital rectal examination, and colorectal cancer screening *(age 40 and over)*	20% Coinsurance, no Deductible
	• Annual routine gynecological visit • Pap test	$20 per PCP Visit; $30 per Specialist Visit 20% Coinsurance, no Deductible
Emergency Services for Life-Threatening Conditions	• Hospital emergency room • Diagnostic x-rays, laboratory services, etc.	20% Coinsurance after Deductible
	• Physician care	$20 per PCP Visit; $30 per Specialist Visit
Mental Illness and Substance Abuse Services	• Outpatient Visit – authorization required in advance of care	$30 per Visit
	• Outpatient Hospital • Inpatient and partial days of care	20% Coinsurance after Deductible
	• Employee Assistance Program (EAP) (four free Visits per incident)	No Coinsurance, no Deductible

*Specialist: Any provider other than your PCP.
**Allowable Charge (AC): See Definitions section.

Your Member Handbook may be printed at any time from the following Web sites: **www.thelocalchoice.virginia.gov** or **www.anthem.com**.